

EFT Electronic Funds Transfer

EXPEDITES ACCESS TO CASH BY 3 - 7 DAYS!



DEPOSITS ARE MADE THE DAY THE PAPER
CHECKS ARE MAILED!

TIMELY AND COST EFFECTIVE!

RHODE ISLAND MEDICAL ASSISTANCE PROGRAM AUTHORIZATION FOR DIRECT DEPOSIT

Complete the section below and attach a copy of a voided check for a checking account, or a copy of a deposit slip for a savings account. The transaction routing number can be obtained from your bank.

PROVIDER NAME	PROVIDER NUMBER

BANK NAME	TRANSACTION ROUTING NUMBER
BANK ADDRESS	ACCOUNT NUMBER
BANK PHONE NUMBER	CHECKING _____ SAVINGS _____

I agree to keep, and disclose upon request to authorized agencies, records which disclose fully the extent of payments claimed from the services rendered to recipients or the Medical Assistance Program. I accept as payment in full the amount paid by the Medical Assistance Program for claims submitted with the exception of authorized cost sharing by recipients. I understand payment of this claim is from state and federal funds and that any false claims, statements, documents or concealment of a material fact may be prosecuted under state or federal law. This is to certify that the information submitted to obtain this payment is true, accurate and complete.

I authorize the electronic transfer of Rhode Island Medical Assistance payments made to the above provider number. I understand that I am responsible for the validity of the above information.

Signature

Date

*****EDS USE ONLY*****

DATE RECEIVED	INITIALS
DATE SUBMITTED	INITIALS